UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

PROVIGIL (modafinil)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Pt. must be age 9 years or older

Covered for diagnosis:

- Narcolepsy- Amphetamines or Methylphenidate must be tried first. Dose limited to 400mg qd.
- Treatment to offset sedation related to multiple sclerosis treatment modalities**.** Dose limited to 200mg qd.
- Daytime somnolence due to Obstructive sleep apnea**, must be on C-pap.** Dose limited to 200mg qd.
- Shift Work Sleep Disorder, **must be working night shifts.** Provide documentation of a treatment plan that demonstrates excessive sleepiness at work, insomnia when the patient should be sleeping. Patient must have a three month trial of sleep aids. Dose limited to 200mg/day.

Authorization:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.